

ANTHEM CENTENNIAL PPO

ANTHEM LIBERTY EPO

KAISER PERMANENTE HMO

SAN LUIS VALLEY HMO

2005 SHORT PLAN YEAR
COMPARATIVE HEALTH PLAN DESCRIPTION FORMS



	Anthem Colorado Health Plan Description Form Anthem Blue Cross and Blue Shield Centennial (PPO) Plan for the State of Colorado Effective January 1, 2005 through June 30, 2005	Anthem Colorado Health Plan Description Form Anthem Blue Cross and Blue Shield Liberty Plan for the State of Colorado Effective Jan. 1, 2005 - June 30, 2005	Kaiser Permanente 2005 Colorado Health Plan Description Form Kaiser Foundation Health Plan of Colorado Plan 430P – State of Colorado Group #00225	San Luis Valley HMO 2005 Colorado Health Plan Description Form Health Maintenance Organizations (HMOs) State of Colorado
Part A: Type of Coverage				
1. TYPE OF PLAN	Preferred provider plan	Preferred provider plan	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
2. OUT-OF-NETWORK CARE COVERED?	Yes, but patient pays more for out-of-network care. ¹	Only for emergency care ¹	Only for Emergency Care ¹	Only for emergency and urgent care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado	Plan is available throughout Colorado	Denver/Boulder Plan is available only in the following areas: Denver, Broomfield and Boulder Counties and portions of Adams, Arapahoe, Clear Creek, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld Counties. Colorado Springs Plan is available only in the following areas: portions of Douglas, Elbert, El Paso, Fremont, Park, Pueblo and Teller Counties.	Plan is available only in the following counties: Alamosa, Conejos, Costilla, Mineral, Rio Grande, and Saguache
Part B: SUMMARY OF BENEFITS				
	Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance options reflect the amount the carrier will pay.	Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance options reflect the amount the carrier will	Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options	Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

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			pay.	reflect the amount the covered person will pay.	
	IN-NETWORK	OUT-OF-NETWORK		IN-NETWORK ONLY (Out-of-Network care is not covered except as noted)	
4. ANNUAL DEDUCTIBLE	a) Individual - \$1,000 b) Family - \$2,000 for all family members	a) Individual - \$2,000 b) Family - \$4,000 for all family members	a) Individual - No deductibles b) Family - No deductibles	a) Individual - No deductibles b) Family - No deductibles ²	No Deductibles
5. OUT-OF-POCKET ANNUAL MAXIMUM	\$2,500 (member paid coinsurance) + Deductible individual or \$5,000 (member paid coinsurance) + Deductible family. The in-network out-of-pocket maximum is not applied towards the out-of-network out-of-pocket maximum. Eligible charges for Other Mental Health Care and Alcohol and Substance Abuse are included in the out-of-pocket annual maximum. ²	\$5,000 (member paid coinsurance) + Deductible individual or \$10,000 (member paid coinsurance) + Deductible family The out-of-network out-of-pocket maximum is not applied towards the in-network out-of-pocket maximum. Eligible charges for Other Mental Health Care and Alcohol and Substance Abuse are included in the out-of-pocket annual maximum. ²	a) Individual - \$1000 (member paid coinsurance) + copayments b) Family - \$3000 (member paid coinsurance) aggregate + copayments Eligible charges for Other Mental Health Care and Alcohol and Substance Abuse are included in the out-of-pocket annual maximum. ²	a) Individual - \$3,000/Individual b) Family - \$6,000/Family ³ c) Is deductible included in the out-of-pocket maximum? Not applicable	a) Individual - 2 X annual premium ² b) Family – 2 X annual premium
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum	No lifetime maximum	No Lifetime Maximum	No Lifetime Maximum	No Lifetime maximum (See Transplants, Line #24)
7A. COVERED PROVIDERS	PPO Provider Network. See provider directory for complete list.	All providers licensed or certified to provide covered benefits.	Anthem Blue Cross and Blue Shield PPO Provider Network. See provider directory for complete list.	Colorado Permanente Medical Group, P.C. See Provider Directory for complete list	All physicians in the San Luis Valley six-county service area; approximately 1,000 specialty providers in Colorado; 15 Colo. hospitals. See provider directory for complete list.

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7B. With respect to network plans, are all of the providers listed in 7A accessible to me through my primary care physician?	Yes	Not applicable	Yes	Not applicable - this is not a network plan	Yes
8. ROUTINE MEDICAL OFFICE VISITS	80% after deductible	60% after deductible	100% after \$50 per office visit copayment.	\$30 copay per primary care office visit \$50 copay per specialist office visit ⁴	\$30 per visit copay-PCP \$50 per visit copay-Specialist
9. PREVENTATIVE CARE a) Children's services b) Adults' services	80% not subject to deductible (up to age 13) 80% after deductible	60% not subject to deductible (up to age 13) 60% after deductible	a) Children's services - 100% after \$50 per office visit copayment includes immunizations (up to age 13) b) Adults' services - 100% after \$50 per office visit copayment for routine exam.	a) Children's Services - \$15 copay per visit b) Adult's Services - \$15 copay per visit	\$30 per visit copay-PCP; \$50 per visit copay-Specialist
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care	80% after deductible 80% after deductible	60% after deductible 60% after deductible	a) Prenatal care - 100% after \$50 per office visit copayment b) Delivery & inpatient well-baby care - \$400 copayment per day for the first five days, then 100% until discharge, per admission	a) Prenatal care - \$15 copay per visit b) Delivery & inpatient well baby care - \$1,000 copay per admission ⁵	a. Prenatal care - \$30 per visit copay-PCP; \$50 per visit copay-Specialist b. Delivery & inpatient well baby care - \$250 copay per day; up to maximum of \$1,000 copay per admission

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11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions a) Inpatient care b) Outpatient care c) Prescription Mail Service	80% after deductible Tier 1 generic formulary \$15, tier 2 brand formulary \$40, tier 3 non-formulary \$60, tier 4 self-administered injectable drugs 30%, per prescription up to a 34-day supply. Tier 1 generic formulary \$30, tier 2 brand formulary \$100, tier 3 non-formulary \$150, tier 4 self-administered injectable drugs 30%, per prescription up to a 90-day supply. For the tier 4 self-administered injectable prescription drugs, the 34-day supply maximum coinsurance per prescription is \$250 and \$500 per 90-day supply. Includes coverage for smoking cessation prescription legend drugs when enrolled in an Anthem Blue Cross and Blue Shield approved smoking cessation counseling program, up to	60% after deductible Not covered Not covered	a) Inpatient care - Included in hospital copayment (see line 12) b) Outpatient care - Tier 1 generic formulary \$15, tier 2 brand formulary \$40, tier 3 non-formulary \$60, tier 4 self-administered injectable drugs 30%, per prescription up to a 34-day supply. c) Prescription Mail Service - Tier 1 generic formulary \$30, tier 2 brand formulary \$100, tier 3 non-formulary \$150, tier 4 self-administered injectable drugs 30%, per prescription up to a 90-day supply. For the tier 4 self-administered injectable prescription drugs, the 34-day supply maximum coinsurance per prescription is \$250 and \$500 per 90-day supply. Includes coverage for smoking cessation prescription legend drugs when enrolled in Anthem Blue Cross and Blue Shield approved smoking cessation counseling program, up to \$250 per member per benefit period, \$500 per lifetime. If a provider prescribes a drug for which an FDA-approved Class A generic substitute is available, the benefit will be limited to the cost of the generic substitute. All medically necessary "dispense as written" and "no substitution" prescriptions do not allow a	\$15 generic/\$40 brand per prescription up to a 30 day supply For drugs on our approved list, please contact your Medical Office Pharmacist ⁶	\$15 copay for formulary generic; \$40 copay for formulary brand name; \$60 copay for non-formulary brand name and non-formulary generic. Prescriptions are filled at the lesser of a 30-day supply or 100 unit dose. Two copays required for 90-day supply of maintenance drugs through mail order. 20% copay for injectables. For drugs on our approved list, excluded drugs and injectables subject to the 20% copay contact Customer Service. Not subject to out of pocket maximum.

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	<p>\$250 per member per benefit period, \$500 per lifetime.</p> <p>If a provider prescribes a drug for which an FDA-approved Class A generic substitute is available, the benefit will be limited to the cost of the generic substitute. All medically necessary “dispense as written” and “no substitution” prescriptions do not allow a generic substitution and require prior authorization from Anthem Blue Cross and Blue Shield. If a brand name drug is used when a generic equivalent is available, you pay the brand formulary copayment or nonformulary copayment plus the retail cost difference between the brand name drug and generic substitution. For drugs on our approved list, contact Customer Service at 1-800-843-5621 or 303-831-2384. Prescription drugs will be covered only when received from a participating pharmacy.</p>		<p>generic substitution and require prior authorization from Anthem Blue Cross and Blue Shield. If a brand name drug is used when a generic equivalent is available, you pay the brand formulary copayment or nonformulary copayment plus the retail cost difference between the brand name drug and generic substitution. For drugs on our approved list, contact Customer Service at 1-800-843-5621 or 303-831-2384. Prescription drugs will be covered only when received from a participating pharmacy.</p>		
12. INPATIENT HOSPITAL	80% after deductible	60% after deductible	\$400 copayment per day for first five days then 100% until discharge, per admission	\$1,000 copay per admission	\$250 copay per day; up to maximum of \$1,000 copay per admission

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13. OUTPATIENT / AMBULATORY SURGERY	80% after deductible	60% after deductible	100% after \$200 per surgery copayment	\$150 copay per visit	\$200 copay per procedure.
14. LABORATORY & X-RAY	80% after deductible	60% after deductible	a) Inpatient care - Included in hospital copayment (see line 12) b) Outpatient care - \$50 per office visit copayment or 20% coinsurance if billed by separate provider of care	DIAGNOSTICS a) Laboratory & x-ray – Diagnostic Lab and X-ray – No copay (100% covered) Therapeutic X-ray - \$50 copay per visit b) MRI, nuclear medicine, and other high-tech services – MRI/CAT/PET - \$100 copay per procedure	\$30 copay \$150 copay per procedure for MRI/MRA/CT/PET scans
15. EMERGENCY CARE	80% after deductible ³	60 % after deductible ³	100% after \$100 per emergency room visit copayment (waived if admitted to hospital) in or out-of-network ³	\$100 copay per visit at a Kaiser Permanente designated Plan or non-Plan emergency room, waived if admitted as an inpatient. Payment of non-Plan emergency claims is limited to usual reasonable and customary charges. ^{7, 8}	\$100 copayment per visit (waived if admitted) Emergency Care covered in or out-of-network. ³
16. AMBULANCE	80 % after deductible (limited to \$350 per trip for ground ambulance and \$2,500 per trip for air ambulance)	60% after deductible (limited to \$350 per trip for ground ambulance and \$2,500 per trip for air ambulance)	a) Ground - 100% after \$200 per trip copayment (maximum benefit of \$350 per trip) b) Air - 100% after \$500 per trip copayment (maximum benefit of \$2,500 per trip)	20% coinsurance up to a maximum of \$500 per trip	20% copay per trip. Not waived if admitted, not included in out-of-pocket maximum.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	80% after deductible	60% after deductible	a) Inpatient care - \$400 copayment per day for first five days then 100% until discharge, per admission b) Outpatient care - 100% after \$75 per office visit copayment	\$100 copay per visit at a designated Kaiser Permanente emergency room \$30 copay per visit at a Kaiser Permanente medical office during office hours \$50 copay per after hours visit at designated Kaiser Permanente medical offices	\$50 per urgent care visit copay (\$100 if in emergency room) Urgent care may be received from your PCP or from an urgent care center. Care covered in or out-of-network.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE	Coverage is no less extensive than the coverage provided for any other physical illness. ⁴	Coverage is no less extensive than the coverage provided for any other physical illness. ⁴	Coverage is no less extensive than the coverage provided for any other physical illness. ⁴	Coverage is no less extensive than the coverage provided for any other physical illness. ⁵	Coverage is no less extensive than the coverage provided for any other physical illness. ⁴

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19. OTHER MENTAL HEALTH CARE a) Inpatient care	80% after deductible (limited to 45 full or 90 partial days per member per benefit period combined with out-of-network)	60 % after deductible (limited to 45 full or 90 partial days per member per benefit period combined with in-network)	a) Inpatient care - 50% coinsurance per admission (limited to 45 full or 90 partial days per benefit period combined with Alcohol Abuse benefits (line 20))	a) Inpatient care – 50% coinsurance per admission – up to 45 days each calendar year	a) Inpatient - 50% copay (limited to 45 days)
	b) Outpatient care	80% after deductible (limited to 30 visits per member per benefit period combined with out-of- network and line 20 outpatient alcohol and substance abuse, with no less than \$1,000 in benefits for mental health care)	60% after deductible (limited to 30 visits per member per benefit period combined with in-network and line 20 outpatient alcohol and substance abuse, with no less than \$1,000 in benefits for mental health care).	b) Outpatient care - 50% coinsurance per visit (limited to 30 visits with no less than \$1,000 in benefits per benefit period)	b) Outpatient - \$30 copay per visit up to 20 visits each calendar year. Group visits will be charged at half the copay of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit.
20. ALCOHOL & SUBSTANCE ABUSE a) Inpatient care	80% after deductible limited to medically necessary care	60% after deductible limited to medically necessary care	a) Inpatient care - Alcohol abuse: 50% coinsurance per admission (limited to 45 days per year or 90 partial days per benefit period combined with Mental Health benefits (line 19)) Substance abuse: 50% coinsurance per admission (limited to 30 days per benefit period or 60 days per lifetime)	a) Inpatient Medical Detoxification - \$1,000 copay per admission Detoxification is limited to removing toxic substance from the body. Inpatient Residential Rehabilitation – 50% coinsurance up to 45 days each calendar year	a) Inpatient: 50% copay (covered only for short term detoxification, rehabilitation not covered) Limited to one treatment per contract year, two treatments for lifetime.
	b) Outpatient care	80% after deductible (limited to 30 visits per member per benefit period combined with out-of- network and line 19 outpatient mental health care, with no less than \$500 in benefits for alcohol abuse and no less than \$250 in benefits for substance abuse)	60% after deductible (limited to 30 visits per member per benefit period combined with in-network and line 19 outpatient mental health care, with no less than \$500 in benefits for alcohol abuse and no less than \$250 in benefits for substance abuse)	b) Outpatient care - 50% coinsurance per visit (limited to 20 visits with no less than \$500 in benefits per benefit period for alcohol abuse; limited to 15 visits per benefit period for substance abuse)	b) Outpatient Chemical Dependency - \$30 copay per visit up to 20 visits each calendar year. Group visits will be charged at half the copay of an individual visit, rounded down to the nearest dollar. Two group visits will count as one individual visit.

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21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	80% after deductible (limited to 20 visits each for physical, occupational, and speech therapy combined with out-of-network benefits)	60% after deductible (limited to 20 visits each for physical, occupational, and speech therapy combined with in-network benefits)	a) Inpatient – Included with inpatient hospital copayment (see line 12) b) Outpatient – 100% after \$50 per office visit copayment (limited to 20 visits each for physical, occupational, and speech therapy)	*a) Inpatient - \$1,000 copay per admission for conditions subject to significant improvement within two months *b) Outpatient - \$30 copay per visit for up to two months per condition, or up to 20 visits per condition if 20 or more visits are not received within two months, for conditions subject to significant improvement within two months *Therapy for congenital defects and birth abnormalities is covered for children up to age five for both acute and chronic conditions	a) Inpatient - \$250 copay per day up to maximum of \$1,000 copay per admission. (Limited to 30 days per injury or illness) b) Outpatient - \$30 per visit copay (limited to 30 treatments per injury or illness)
22. DURABLE MEDICAL EQUIPMENT	80% after deductible	60% after deductible	a) Inpatient – Included with inpatient hospital copayment (see line 12) b) Outpatient – 20% coinsurance (limited to a maximum payment of \$3,000 per benefit period, combined with oxygen (line 23), except for prosthetic devices which are not subject to the maximum payment but do reduce the maximum payment of \$3,000)	No copay (100% covered) up to \$2,000 each calendar year within the Service Area. Prosthetic arms and legs covered at 20% coinsurance with no annual maximum See policy for types and circumstances of coverage	50% copay (benefit limited to \$3,000 benefit payment per calendar year, combined with oxygen benefit (line 23), except for prosthetic arms and legs that are not subject to the maximum benefit payment, but does reduce the maximum benefit payment of \$3,000.
23. OXYGEN	80% after deductible	60% after deductible	a) Inpatient care – Included with inpatient hospital copayment (see line 12) b) Outpatient care - 20% coinsurance (limited to a maximum payment of \$3,000 per benefit period, combined with durable medical equipment (line 22))	20% coinsurance	50% copay (limited to \$3,000 benefit payment per calendar year, combined with durable medical equipment benefit (line 22))

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24. ORGAN TRANSPLANTS	80% after deductible	60% after deductible	\$400 copayment per day for first five days then 100% until discharge, per admission	\$1,000 copay per admission – no waiting period. Covered transplants are limited to kidney, kidney/pancreas, pancreas, heart, heart-lung, lung, some bone marrow, cornea and liver, small bowel/small bowel and liver.	\$250 copay per day, up to maximum of \$1,000 copay per admission. Cornea, heart, heart-lung, lung, kidney, kidney-pancreas, liver, bone marrow (only for certain medical conditions), peripheral blood stem cell. \$250,000 Lifetime Maximum Benefit. ⁵
25. HOME HEALTH CARE	80% after deductible (up to 60 visits per benefit period combined with out-of-network benefits)	60% after deductible (up to 60 visits per benefit period combined with in-network benefits)	100% after \$50 per visit copayment (limited to 60 visits per benefit period)	No copay (100% covered) for prescribed medically necessary home health services. Not covered outside the Service Area.	No copay (100% covered) when authorized. Limited to 30 visits per calendar year.
26. HOSPICE CARE a) Inpatient care b) Outpatient care	80% after deductible 80% after deductible	60% after deductible 60% after deductible	a) Inpatient care – 20% coinsurance (limited to 30 days per benefit period) b) Outpatient care – 20% coinsurance (limited to 91 days per benefit period)	No copay (100% covered) for home-based hospice care. Not covered outside the Service Area.	No copay (100% covered) when authorized.
27. SKILLED NURSING FACILITY CARE	Not covered	Not covered	Not covered	No copay (100% covered) for up to 100 days for prescribed skilled nursing facility services at approved skilled nursing facilities. Not covered outside the Service Area.	No copay (100% covered) when authorized; limited to 30 days per calendar year.
28. DENTAL CARE	No dental benefits are available under this medical plan. However, the State of Colorado offers a separate dental plan for eligible employees and dependents. See enrollment materials.		No dental benefits are available under this medical plan. However, the State of Colorado offers a separate dental plan for eligible employees and dependents. See enrollment materials.	Not covered	No dental benefits are available under this medical plan. However, the State of Colorado offers two separate dental plans for eligible employees and dependents. See enrollment materials.
29. VISION CARE	Vision benefits included in this plan can be found on the separate Anthem Vision Summary Description.		Vision benefits included in this plan can be found on the separate Anthem Vision Summary Description.	\$30 copay per vision exam Hardware not covered	\$20 per visit copay limited to one visit every 24 months. Hardware not covered.
30. CHIROPRACTIC CARE	80% after deductible (limited to a maximum payment of \$750 per benefit period combined with out-of-network)	60% after deductible (limited to a maximum payment of \$750 per benefit period combined with in-network)	100% after \$50 per visit copayment (limited to annual payment of \$300)	\$30 copay per visit up to 20 visits each calendar year	Not covered.

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31. SIGNIFICANT ADDITIONAL COVERED SERVICES	<p>BlueCares for You disease management programs that include management for CAD, CHF, ESRD, maternity, asthma, diabetes, and a 24-hour nurse healthline.</p> <p>Hearing aids, exam and fitting not subject to deductible or coinsurance (limited to maximum payment of \$500 every three years combined with out-of-network)</p> <p>Infertility treatment 80%, subject to deductible (limited to a maximum payment of \$2,500 per benefit period combined with out-of-network)</p> <p>When a member desires another professional opinion, they may obtain a second surgical opinion subject to plan provisions.</p> <p>A benefit period begins on the subscriber's effective date, and expires on the following June 30.</p>	<p>BlueCares for You disease management programs that include management for CAD, CHF, ESRD, maternity, asthma, diabetes, and a 24-hour nurse healthline.</p> <p>Hearing aids, exam and fitting not subject to deductible or coinsurance (limited to maximum payment of \$500 every three years combined with in-network)</p> <p>Infertility treatment 60%, subject to deductible (limited to a maximum payment of \$2,500 per benefit period combined with in-network)</p> <p>When a member desires another professional opinion, they may obtain a second surgical opinion subject to plan provisions.</p> <p>A benefit period begins on the subscriber's effective date, and expires on the following June 30.</p>	<p>BlueCares for You disease management programs that include management for CAD, CHF, ESRD, maternity, asthma, diabetes, and a 24-hour nurse healthline.</p> <p>When a member desires another professional opinion, they may obtain a second surgical opinion subject to plan provisions.</p> <p>A benefit period begins on the subscriber's effective date, and expires on the following June 30.</p>	<p>Travel Clinic for pre-travel health risk assessments, immunizations and prescriptions; Mail-order Pharmacy; Health education classes including Smoking Cessation, Stress Management, Women's Health and Diet and Nutrition; Special Services Hospice program for persons who have not yet chosen hospice care; see attached benefit schedule for cancer screening information</p>	<p>Free child car seat program for expectant mothers who meet eligibility criteria; Smoking cessation program - \$150 lifetime benefit; Infertility Services: for diagnosis only - 50% copay. Hearing Aids – Covered up to \$500 once every three (3) years.</p>
PART C: LIMITATIONS & EXCLUSIONS					
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED	Not applicable. Plan does not impose limitation periods for pre-existing conditions. ⁵		Not applicable. Plan does not impose limitation periods for pre-existing conditions. ⁵	Not applicable – Plan does not impose limitation periods for pre-existing conditions. ¹⁰	Not applicable. Plan does not impose limitation periods for pre-existing conditions. ⁶

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33. EXCLUSIONARY RIDERS. Can an individual’s specific, pre-existing condition be entirely excluded from the policy?	No	No	No	No
34. HOW DOES THIS POLICY DEFINE A "PRE-EXISTING CONDITION?"	Not applicable. Plan does not exclude coverage for pre-existing conditions.	Not applicable. Plan does not exclude coverage for pre-existing conditions.	Not applicable. Plan does not exclude coverage for pre-existing conditions.	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy, a list of exclusions is available immediately upon request from your carrier or plan sponsor (e.g. employer). Review them to see if a service or treatment you may need is excluded from the policy.	Exclusions vary by policy, a list of exclusions is available immediately upon request from your carrier or plan sponsor (e.g. employer). Review them to see if a service or treatment you may need is excluded from the policy.	Exclusions vary by policy, a list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g. employer). Review them to see if a service or treatment you may need is excluded from the policy.	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier. Review them to see if a service or treatment you may need is excluded from the policy.
PART D: USING THE PLAN				
	IN-NETWORK	OUT-OF-NETWORK		
36. Does the enrollee have to obtain a referral and / or prior authorization for specialty care in most or all cases?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield	No	Yes
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes	Yes	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield	No	No
39. What is the main customer service number?	303-831-2384 or 1-800-843-5621		303-831-2384 or 1-800-843-5621	(303) 338-3800
40. Whom do I write / call if I have a complaint or want to file a grievance?	Anthem BCBS Complaints and Appeals 700 Broadway Denver, CO 80273 303-831-2384 or 1-800-843-5621 ⁶		Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 303-831-2384 or 1-800-843-5621 ⁶	Customer Service Center 2500 S. Havana Street Aurora, CO 80014 Telephone (303) 338-3800 ¹¹
				Complaint & Grievance Coordinator San Luis Valley HMO, Inc. 700 Main Street, Suite 100 Alamosa, CO 81101 1-800-475-8466 or 1-719-589-3696 ⁷

		Anthem Colorado Health Plan Description Form Anthem Blue Cross and Blue Shield Centennial (PPO) Plan for the State of Colorado Effective January 1, 2005 through June 30, 2005			Anthem Colorado Health Plan Description Form Anthem Blue Cross and Blue Shield Liberty Plan for the State of Colorado Effective Jan. 1, 2005 - June 30, 2005			Kaiser Permanente 2005 Colorado Health Plan Description Form Kaiser Foundation Health Plan of Colorado Plan 430P – State of Colorado Group #00225			San Luis Valley HMO 2005 Colorado Health Plan Description Form Health Maintenance Organizations (HMOs) State of Colorado		
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?		FOR IN-NETWORK & OUT-OF-NETWORK Write to: Colorado Division of Insurance ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202			Write to: Colorado Division of Insurance ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202			Colorado Division of Insurance ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202			Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202		
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.		FOR IN-NETWORK & OUT-OF-NETWORK Policy form #96744 Large group			Policy form #98467 Large group			Policy forms LGEOC-DENCOS(01-05) and GA-DENCOS(01-05) Large Group <i>(Will be available by January 1, 2005)</i>			Policy Form SLV/SOC2005 Large Group Only		
PART E: COST										PART E: COST AND MEDICAL EXPENDITURES			
43. What is the cost for this plan?	Employee Portion	State Contribution	Full Premium	Employee Portion	State Contribution	Full Premium	Employee Portion	State Contribution	Full Premium	Employee Portion	State Contribution	Full Premium	
Employee Only	\$44.18	\$178.06	\$222.24	\$168.30	\$178.06	\$346.36	\$83.30	\$178.06	\$261.36	\$87.10	\$178.06	\$265.16	
Employee + 1 Dependent	\$137.70	\$303.50	\$441.20	\$385.88	\$303.50	\$689.38	\$215.96	\$303.50	\$519.46	\$223.48	\$303.50	\$526.98	
Employee + 2/More Dependents	\$196.36	\$420.02	\$616.38	\$543.78	\$420.02	\$963.80	\$305.92	\$420.02	\$725.94	\$316.74	\$420.02	\$736.76	

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PART F: PHYSICIAN PAYMENT METHODS, & PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION & PROFIT Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan, may request answers to questions listed below. The request may be made orally or in writing to the agent marketing the plan or directly to the insurance company and shall be answered within five (5) working days of the receipt of the request. <ul style="list-style-type: none"> • What are the three most frequently used methods of payment for primary care physicians? • What are the three most frequently used methods of payment for physician specialists? • What other financial incentives determine physician payment? • What percentage of total Colorado premiums are spent on health-care expenditures as distinct from administration and profit? 			PART F: PHYSICIAN PAYMENT METHODS & PLAN EXPENDITURES FOR HEALTH EXPENSE, ADMINISTRATION & PROFIT Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan, may request answers to questions listed below. The request may be made orally or in writing to the plan administrator and shall be answered within five (5) working days of the receipt of the request. <ul style="list-style-type: none"> • What are the three most frequently used methods of payment for primary care physicians? • What are the three most frequently used methods of payment for physician specialists? • What other financial incentives determine physician payment? What percentage of total Colorado premiums are spent on health-care expenses as distinct from administration and profit? For San Luis Valley contact: Operations Manager San Luis Valley HMO, Inc. 700 Main, Suite 100 Alamosa, CO 81101 1-800-475-8466 or 1-719-589-3696	

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ENDNOTES:	<p>¹“<u>Network</u>” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) then if you don’t (i.e., go out-of network).</p> <p>²“<u>Out-of Pocket maximum</u>” The maximum amount you will pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.</p> <p>³“<u>Emergency care</u>” means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and</p>	<p>¹“<u>Network</u>” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) then if you don’t (i.e., go out-of network).</p> <p>²“<u>Out-of Pocket maximum</u>” The maximum amount you will pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.</p> <p>³“<u>Emergency care</u>” means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and</p>	<p>¹“<u>Network</u>” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don’t (i.e., go out-of network).</p> <p>²“<u>Out-of Pocket maximum</u>” The maximum amount you will pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.</p> <p>³“<u>Emergency care</u>” means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life-or limb-threatening emergency existed.</p> <p>⁴“<u>Biologically based mental illnesses</u>” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.</p> <p>⁵“<u>Waiver of pre-existing condition</u></p>	<p>¹“<u>Network</u>” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don’t (i.e., go out-of network).</p> <p>²“<u>Deductible</u> “ means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that subject to deductibles may be noted in boxes 8 through 31.</p> <p>³“<u>Out-of Pocket maximum</u>” The maximum amount you will pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.</p> <p>⁴“<u>Routine medical office visits</u>” include</p>	<p>¹“<u>Network</u>” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don’t (i.e., go out-of network).</p> <p>²“<u>Out-of Pocket maximum</u>” The maximum amount you will pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.</p> <p>³“<u>Emergency care</u>” means services delivered by an emergency care facility, that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.</p> <p>⁴“<u>Biologically based mental illnesses</u>” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.</p>

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	<p>acting reasonably would have believed that an emergency medical condition or life-or limb-threatening emergency existed.</p> <p>⁴<u>Biologically based mental illnesses</u>” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.</p> <p>⁵<u>Waiver of pre-existing condition exclusions</u>. State law requires carriers to waive some or all pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.</p> <p>⁶<u>Grievances</u>. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.</p>	<p>acting reasonably would have believed that an emergency medical condition or life-or limb-threatening emergency existed.</p> <p>⁴<u>Biologically based mental illnesses</u>” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.</p> <p>⁵<u>Waiver of pre-existing condition exclusions</u>. State law requires carriers to waive some or all pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.</p> <p>⁶<u>Grievances</u>. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.</p>	<p>exclusions. State law requires carriers to waive some or all pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.</p> <p>⁶<u>Grievances</u>. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.</p>	<p>physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.</p> <p>⁵<u>Well baby care</u>” includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.</p> <p>⁶<u>Prescription Drugs</u>” include expendable medical supplies for the treatment of diabetes. Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or nonpreferred.</p> <p>⁷<u>Emergency care</u>” means services delivered by an emergency care facility, that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.</p> <p>⁸Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours</p>	<p>⁵“Transplants” will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.</p> <p>⁶<u>Waiver of pre-existing condition exclusions</u>. State law requires carriers to waive some or all pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.</p> <p>⁷<u>Grievances</u>. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.</p>

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				care, then urgent care copayments apply. ⁹ <u>Biologically based mental illnesses</u> ” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. ¹⁰ <u>Waiver of pre-existing condition exclusions.</u> State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details. ¹¹ <u>Grievances.</u> Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.	

ADDITIONAL PLAN INFORMATION:

Anthem Centennial PPO

Anthem Vision Summary of Benefits

This Summary Plan Description outlines the vision benefits available to you through the Anthem Vision Plan. This is a summary of your vision benefit. Please review your benefit certificate for plan details. For eligibility definitions please contact your group administrator.

Anthem Vision Provider Network: Anthem Vision contracts with many providers which includes independent optometrists and ophthalmologists as well as retail locations. Anthem members have access to approximately 10,000 conveniently located providers nationwide. Members may call Anthem Vision toll-free (800-231-2583) or visit

www.anthem.com any time for provider locations. Schedule an appointment with your Anthem provider; identify yourself as an Anthem vision member for fast, paperless determination and confirmation for benefits.

Network Provider: Maximum benefits are achieved when members access their benefits from an **Anthem** Participating Vision Provider. Copayment(s) may apply to in-network benefits.

Non-Network Vision Provider Reimbursements: Members may go to a non-participating (non-network) vision provider and pay the provider directly for their examination. Members may then submit an original itemized invoice along with the Member’s I.D. number to **Anthem Vision** for reimbursement according to the Non-Par Reimbursement schedule identified in the Summary of Benefits.

Material: **Anthem** Providers agree to Preferred Pricing that is significantly below retail. Members are able to achieve substantial savings on frames, lenses or contact lenses, lens treatments, specialized lenses and various sundry items. Members may save approximately 20% to 40% or more off retail when they visit an **Anthem** Provider.

Copayment(s): Copayment amounts are applicable to Network Vision Provider examinations.

Anthem Vision Benefits	Member Benefits from Network Provider	Non-Par Reimbursement
Vision Examination: Each member is entitled to a comprehensive vision examination by an Anthem Vision Provider. This is a vision examination only and does not cover a separate contact lens professional fitting fee. Availability: Once every 12 months*	Copayment \$20	Up to reimbursement of \$35
Materials: Prescription lenses and frames	Available at Anthem Vision Preferred Prices	Not covered
Contact Lenses:	Available at Anthem Vision Preferred Prices	Not covered

*Benefits are available from the last date of service.

Limitations and Exclusions:

This is a primary vision care benefit and is intended to cover only eye examinations. Materials and any items not covered may be purchased at Preferred Pricing from an Anthem Vision Provider. In addition, the examination is only payable while the Group and individual Member coverage is in force.

- Orthoptics or vision training and any supplemental testing.
- Medical or surgical treatment of the eyes.
- An eye exam or corrective eyewear required by an employer as a condition of employment.
- Any injury or illness covered under Worker’s Compensation or similar law, or which is work related.
- Sub-normal vision aids.

- Experimental or non-conventional treatments or devices.
- Safety eyewear.

Selected Benefit Descriptions
Colorado Health Plan Description Form Addendum
Kaiser Foundation Health Foundation Plan of Colorado

Benefit	Benefit Level		
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	<i>Kaiser Permanente Coverage for Cancer Screening</i>		
	Breast Cancer:		
	Screening	Coverage	Kaiser Permanente Recommendation
	Clinical breast exam	Not limited	As jointly determined by physician and patient
	Mammogram	Available for all women upon request beginning at age 40	At least every 2 years beginning at age 50
	Genetic testing for inherited susceptibility for breast cancer	Available upon referral of a Kaiser Permanente provider for those women who meet the following criteria: <ul style="list-style-type: none">• Patients with a 10% or greater risk of inherited gene defect	
	Colon and Rectal Cancer:		
	Screening	Coverage	Kaiser Permanente Recommendation
	Fecal occult blood test (FOBT)	Not limited	Annually beginning at age 50 through age 75
	Flexible sigmoidoscopy	Not limited	Every 5-10 years beginning at age 50 through age 75
	Barium enema	Not limited	Every 5 years beginning at age 50 through age 75
	Colonoscopy	Every 10 years, more frequently for high risk patients – as determined by a Kaiser Permanente physician	Every 10 years, more frequently for high risk patients – as determined by a Kaiser Permanente physician
	Cervical Cancer:		
	Screening	Coverage	Kaiser Permanente Recommendation
	Pap test	Not limited	Annually for women under age 26. After that, recommended every 2 years after 3 normal annual screenings, for women up to age 65.
	Prostate Cancer:		
	Screening	Coverage	Kaiser Permanente Recommendation
	Digital rectal exam	Not limited	Patients should discuss the benefits and risks of this test with their Kaiser Permanente physician.
	Serum prostatic specific	Not limited	Patients should discuss the benefits and risks of this test with their

		antigen (PSA)		Kaiser Permanente physician. Not recommended for those over 70.